Emotional demands, compassion and mental health in social workers

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Abstract

Background: Compassion, described as the act of providing care based on empathy, dignity and respect, is intrinsic to effective health and social care. Although delivering compassionate care has wide-ranging benefits for service users, more insight is needed into its effects on health and social care professionals. The emotional demands of 'helping' work can engender compassion fatigue that may impair wellbeing, whereas compassion satisfaction and feelings of compassion towards the self could be protective.

Aims: To examine the effects (direct and indirect) of compassion satisfaction, compassion fatigue and self-compassion on mental health in a cohort of social workers.

Methods: We used validated scales to measure emotional demands, compassion satisfaction and fatigue, and self-compassion and the General Health Questionnaire-12 to assess mental health. We tested the main and moderating effects of emotional demands and the three facets of compassion using hierarchical regression analysis.

Results: The study sample comprised 306 social workers (79% female). Participants who reported higher levels of compassion satisfaction and self-compassion tended to report better mental health, whereas compassion fatigue was a significant risk factor for wellbeing. The models explained 44% - 53% of the variance in mental health symptoms. We found some evidence that compassion satisfaction and self-compassion buffer the negative effects of emotional demand on mental health, contributing 2% and 3% respectively to the incremental variance.

Conclusions: Our findings suggest that evidence-based interventions are needed to reduce compassion fatigue and enhance compassion satisfaction and self-compassion in social care work. We consider ways to accomplish this using targeted interventions.

Key words: Compassion; self-compassion; mental health; emotional demands; social work

Introduction

Providing high quality compassionate care is a fundamental aim of the helping professions. The need to demonstrate compassion and respect for human dignity is enshrined in the codes of conduct for health and social care staff and a core value in the NHS constitution [1,2]. Research findings show that being treated with compassion has many benefits for patients; for example, by increasing compliance with professional advice, improving satisfaction with services, and enhancing health and quality of life [3]. Providing compassionate care requires kindness, empathy and sensitivity, but it has been conceptualised as a three-stage process requiring professionals to notice (be aware of somebody's distress), feel (imagine the distress suffered by another person and feel empathic concern for them) and respond (be motivated to alleviate their suffering) [4]. There is also a moral element, whereby choosing not to show compassion may compound the pain or distress experienced by another person [5]

Research findings suggest that helping professionals can gain considerable satisfaction from connecting with and supporting service users [6]. 'Compassion satisfaction' [7] is commonly identified as one of the most rewarding and motivating aspects of helping work that can also enhance feelings of personal accomplishment and fulfilment [8,9]. Satisfaction with providing compassionate care can also offer protection against stress and burnout, an acknowledged risk factor for health and social care professionals, and help build emotional resilience [9,3]. Nonetheless, providing care and support to people in distress requires emotional effort that can, over time, deplete the caregiver's emotional resources. In turn, this can engender compassion fatigue, a sub-category of burnout characterised by feelings of indifference to the suffering of others [10]. There is some evidence that it can increase the risk of mental and physical health problems and other negative outcomes such as insomnia and substance abuse in helping professionals [11,12].

Compassion fatigue can also have negative implications for organisations and service users. It has been associated with absenteeism, staff turnover and poor morale and impaired professional judgement [13,14]. Moreover, as compassion fatigue can compromise the ability to provide empathic and responsive care, the quality of relationships between professionals and service users may be affected, and their distress may be intensified rather than alleviated [15]. Although there is some evidence that it's negative effects on staff wellbeing may be attenuated or reversed by feelings of compassion satisfaction, compassion fatigue may be particularly damaging as it can overwhelm any positive feelings towards service users that may arise [16].

Compassion not only involves alleviating the suffering of others, it can also be directed towards the self. Self-compassion is thought to have three components, each with opposing states [17]: self-kindness vs self-judgement: being warm and understanding towards ourselves when we suffer, fail or feel inadequate rather than being self-critical and hostile; common humanity vs isolation: recognising that suffering and feelings of inadequacy and disappointment are universal and not something that happens to us alone; and mindfulness vs over-identification: taking a balanced and non-judgemental approach to our negative emotions, so they are neither avoided or exaggerated. Research findings indicate that self-compassion can improve coping abilities, reduce the risk of burnout and improve life satisfaction [18]. There may also be benefits for others, as self-compassion can increase feelings of empathy and improve the quality of interpersonal relationships [19].

Some insight has been gained into the nature and the implications of compassion fatigue, compassion satisfaction and self-compassion for the wellbeing of helping

professionals, but few studies have included all three elements of compassion. Moreover, little is known about the mechanisms through which they influence wellbeing. This study examines the direct and indirect effects of the three aspects of compassion on the mental health of social workers. As yet, most research on compassion has focused on nurses. Social work is particularly emotionally challenging and, although rewarding, the risk of mental health problems and burnout is high [20]. We initially examine the independent effects of compassion fatigue, compassion satisfaction and self-compassion on the mental health of this group of workers. We also consider whether the three aspects of compassion moderate relationships between emotional demands and mental health. More specifically we aim to identify: whether compassion fatigue exacerbates the negative effects of emotional demands on mental health; and whether compassion satisfaction and self-compassion protect wellbeing.

Methods

We obtained data via an online survey that was distributed by a professional body that represents social workers in the UK. The link to the survey was made available via a bulletin to members. Sex, age and job experience were co-variates in each model. For all scales used in this study, higher scores represent higher levels of the variable measured.

- The seven-item Emotional Workload scale [21] measured emotional demands with an example item being 'Does your work demand a lot from you emotionally?' Items are rated on a four-point scale ranging from 1 = 'never' to 4 = 'always'.
- The Professional Quality of Life Scale [22] assessed compassion satisfaction and fatigue Ten items each measured compassion satisfaction (e.g. 'I have happy thoughts and feelings about those I help) and compassion fatigue (e.g. 'I feel overwhelmed as

my caseload seems endless'. Both use a five-point rating scale from 1 = 'never' to 5 = 'very often'.

- A 12-item questionnaire developed by Raes et al. (2011) [23] measured self-compassion (encompassing self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification). An example item is: 'I try to see my failings as part of the human condition'. Items are assessed on a five-point scale ranging from 1 = 'almost never' to 5 = 'almost always'. This measure can be used to provide an overall score for self-compassion or its six individual components. We calculated mean scores for each of the six aspects of self-compassion for information and used total scores in the regressions.
- We used the General Health Questionnaire (GHQ-12: [24] to measure mental health. This scale is widely used to assess minor psychiatric disorders in employees. Participants indicate the frequency or severity with which they have experienced a range of symptoms compared to how they feel 'normally'. A four-point scale ranging from 'better than usual' to 'much worse/more than usual' is used to score items. In this study, we followed the Likert method that is recommended when using parametric statistics [25]. Item responses are rated from 0 to 3 and a score across items is calculated and used as an outcome variable in the regression equation.

We computed three separate hierarchical linear regressions to test the main effects of emotional demands and the three aspects of compassion (i.e. compassion satisfaction, compassion fatigue and self-compassion), with the mean GHQ score as the outcome variable. We entered gender, age and experience in the job role in step 1 to control for their potential effects, entered emotional demands and each of the three compassion variables at step 2 and

added the moderation terms (emotional demands X compassion satisfaction/fatigue and self-compassion) into the third and final step to identify their potential moderating effects.

The study was approved by the ethics committee of the School of Psychology at the University of Bedfordshire, UK.

Results

Three hundred and six social workers employed in the UK completed the questionnaire. As the survey was made available via a bulletin, it was not possible to establish a response rate. Reflecting the gender imbalance in social work in the UK, the majority of respondents (79%) were female. In terms of age, most (69%) were over 45 and 41% were over 55. Three-quarters of the sample (75%) had been qualified for at least 10 years and 62% for more than 15 years.

Table 1 provides the mean scores, standard deviations and Cronbach alphas for each of the variables. It also includes the descriptive statistics for the six components of self-compassion. Mean scores for emotional demands and compassion fatigue were well below the theoretical mid-point for each scale (i.e. 3), whereas compassion satisfaction and self-compassion were slightly above this point. In terms of the sub-scales of self-compassion, the mean scores for the positive aspects were moderate (self-kindness and common humanity) or high (mindfulness). Nonetheless, the means for self-judgement, isolation and over-identification were also higher than the theoretical mid-point of the scale.

The main and moderating effects of compassion fatigue, compassion satisfaction and self-compassion are shown in Table 2. Gender, age and job experience, entered into step 1 of

each equation, accounted for 9% of the variance in mental health symptoms. Only job experience made a significant contribution in a negative direction (β = -.25, p<0.001). Equation 1 (with compassion satisfaction as a potential moderator) explained a total of 49% of the variance in mental health symptoms, with the main effects of emotional demands (β = .40, p<0.001) and compassion satisfaction (β = -.44, p<0.001) found in step 2 explaining 40% of the variance in mental health symptoms. The moderation term entered in step 3 added a further 2% to the incremental variance (β = -.46, p<.001). Equation 2 (with compassion fatigue as a potential moderator) accounted for 62% of the variance in mental health scores, with the main effects of emotional demands (β, = .17, p<0.001) and compassion fatigue (β = .46, p<0.01) together contributing a total of 53%. The moderation term made no significant contribution to the variance in mental health scores. Equation 3 (with self-compassion as a potential moderator) explained 44% of the variance in mental health scores, with emotional demands (β = .43, p<0.001) and self-compassion (β = -.34, p<0.001) accounting for 32%. The moderation term explained a further 3% to the overall variance (β = -.58, p<0.01).

Discussion

This study highlights the risks and benefits for the wellbeing of social workers, of providing compassionate care. We found evidence that compassion fatigue is a risk factor for mental health, whereas compassion satisfaction and self-compassion are beneficial for wellbeing. Satisfaction gained from relationships with service users and feelings of compassion towards the self may also protect social workers from the negative effects of the emotional demands of the work on their mental health. Our findings also suggest that compassion fatigue has strong direct effects on the mental health of social workers but does not exacerbate the risks to wellbeing when emotional demands are high.

A strength of our study is that we identified the potential risks and benefits of aspects of compassion in a sample of social workers. The results can inform targeted interventions to improve wellbeing in this highly stressed profession by reducing compassion fatigue and enhancing compassion satisfaction and self-compassion. However, the study has several limitations. Although we used reliable and well-validated scales, we rely on cross-sectional self-reported data. Nonetheless, insight into people's emotional reactions to work, such as compassion satisfaction and fatigue, can only be gained by subjective ratings. More objective assessment of mental health status would strengthen the findings, however, but there is evidence that the measure we used (the GHQ: 12) corresponds well with outcomes from clinical standardised interview [26].

A further limitation of our study is that the sample may not reflect the characteristics and experiences of the wider population of social workers. Our inability to establish a response rate, and to consider the characteristics of social workers who failed to respond, may limit our ability to extend the findings more widely. Respondents were predominantly female and middle-aged, which corresponds well with the wider population of social workers at the time the study was conducted, but they were more experienced than the national average [27]. The extent of emotional demand and compassion fatigue reported by our sample was only moderate and the mean score for mental health symptoms not unduly high compared to other studies of health and social care professionals [25]. This is surprising, considering that a high proportion of our sample (46%) were working with children and families, which is generally considered a "high stress" specialisation [11]. These findings might be explained by survivor effects, where social workers who were less able to cope with the emotional demands of the role may have moved to other specialities or left the profession entirely.

Our findings support and extend those of previous research that has examined the effects of compassion satisfaction and fatigue and self-compassion separately [12,16,18]. The design enabled us to examine the main effects of the three aspects of compassion on the mental health of social workers. It also allowed us to consider whether experiencing compassion fatigue exacerbated the risks of high emotional demands and whether compassion satisfaction and self-compassion reduced that risk. These findings can guide the development of interventions to improve the wellbeing of social workers. Many health and social care practitioners complete their training with little knowledge of how to maintain their mental health and avoid burnout [28]. The need for an 'emotional curriculum' that prepares and supports staff for the emotional demands of practice from recruitment to retirement is widely recognised [20]. Strategies are required to reduce the risk of compassion fatigue and increase opportunities for helping professionals to gain compassion satisfaction. Initiatives to encourage the qualities that underpin self-compassion seem particularly important as it appears to benefit mental health directly and provides some protection from the negative effects of emotional demands.

In order to improve the wellbeing of helping professionals, we recommend a multi-level approach with input at the organisational as well as the individual level. There is evidence that compassion fatigue is not caused by intrinsic aspects of helping work, such as the need to provide sustained, empathic care, but organisational factors such as inadequate resources, training and feedback [20]. To help staff cope with the emotional demands of helping work, social care organisations should ensure that workloads are not excessive, staffing levels are optimum and high-quality supervision is available. As well as reducing the risk of compassion fatigue at source, this will foster an organisational culture that enables

professionals to forge compassionate, satisfying relationships with service users that will sustain rather than drain their emotional resources and support their wellbeing.

Individuals who do emotionally-demanding work also have some responsibility for increasing their capacity for self-compassion and protecting their wellbeing. Mindfulness-based stress reduction techniques and acceptance-commitment therapy can improve empathy and compassion for others and for oneself and reduce the risk of compassion fatigue [28,29]. Compassion-focused expressive writing can also be effective in reducing unhealthy self-criticism and promoting self-reflection in clinical samples [30] and may also help enhance self-compassion in professionals. Finally, peer coaching techniques using a strengths-based approach, could be used to explore opportunities to build self-compassion and introduce healthy self-care practices [20].

There are several areas where future research is needed. Although our study was conducted with social workers, the findings are likely to be relevant to other professionals who do emotionally demanding work and are at risk of compassion fatigue and mental health problems. Longitudinal research, particularly using daily diary methodology, will help inform interventions by identifying the organisational and individual factors that encourage the development of compassion satisfaction and compassion fatigue. We also need more knowledge of the working experiences and personal characteristics that foster self-compassion among health and social care professionals. It might be assumed that kind and compassionate feelings towards oneself promote healthy self-care behaviours that, in turn, protect physical and mental health. There is some evidence that helping professionals may consider themselves to be self-compassionate but are frequently reluctant to prioritise their own wellbeing for fear of seeming self-indulgent or even selfish [28]. It is therefore vital to

identify ways to translate these positive attitudes into action. Finally, as less experienced respondents tended to report poorer mental health, future research should focus on more junior staff who may not have developed the resources required to withstand the emotional demands of helping work.

Key points:

What is already known about this subject?

- There is some evidence that health and social care professionals are at risk of compassion fatigue and that this can threaten their wellbeing.
- Satisfaction gained from forging compassionate relationships with service users and feelings of compassion towards the self may protect the wellbeing of helping professionals.
- Most research has been conducted with nurses. Moreover, little is known about whether compassion fatigue exacerbates the negative effects of emotional demands on the mental health of helping professionals, or whether compassion satisfaction and self-compassion helps them cope more effectively.

What does this study add?

- Our findings highlight the negative effects of compassion fatigue and the positive effects of compassion satisfaction and self-compassion on the mental health of social workers.
- We also find evidence that compassion satisfaction and self-compassion can protect the wellbeing of social workers (and potentially other helping professionals) under conditions of high emotional demand.

What impact this study might have on practice or policy?

- Our findings raise awareness of the risks of compassion fatigue to the mental health of social workers and the potential benefits of compassion satisfaction and compassion towards the self.
- Identifying signs of compassion fatigue and lack of compassion satisfaction can help practitioners take action to protect wellbeing at an early stage.
- In order to protect the mental health of helping professionals, it is crucial to recognise the need for compassion towards the self as well as others and encourage healthy self-care practices.

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Table 1. Descriptive data and internal consistency for each of the study variables and the individual aspects of self-compassion

Variable	Mean (SD)	Range	Cronbach alpha
Emotional demands	2.25 (0.52)	1-5	0.83
Compassion satisfaction	3.42 (0.48)	1-5	0.91
Compassion fatigue	1.90 (0.51)	1-5	0.82
Self-compassion (total)	3.39 (0.65)	1-5	0.88
Self-kindness	3.30 (0.78)	1-5	0.71
Self-judgement	3.22 (1.00)	1-5	0.83
Common Humanity	3.46 (0.80)	1-5	0.68
Isolation	3.20 (0.96)	1-5	0.72
Mindfulness	3.98 (0.73)	1-5	0.75
Over-identification	3.21 (0.95)	1-5	0.68
GHQ-12	0.99 (0.47)	0-3	0.90

Table. 2 Main and moderating effects of variables on mental health (GHQ scores)

		Mental health symptoms		
		ΔR^2	β	(95% CI)
Compassion satisfaction				
Step 1		.09***		
Gender			.04	(-0.08 to 0.15)
Age			-.06	(-0.07 to 0.03)
Job experience			-.25***	(-0.16 to 0.05)
Step 2		.40***		
a) Emotional demands			.40***	(-0.16 to -0.05)
b) Compassion satisfaction			-.44***	(0.25 to 0.39)
Step 3				
a x b		.02**	-.57**	(-1.02 to -0.23)
Total R^2	**49**			
Compassion fatigue				
Step 1		.09		
Gender			.04	(-0.08 to 0.15)
Age			-.06	(-0.07 to 0.03)
Job experience			-.25***	(-0.16 to 0.05)
Step 2		.53***		
a) Emotional demands			.17***	(0.07 to 0.21)
b) Compassion fatigue			.50***	(0.49 to 0.63)
Step 3				
A x b		.00	-.31	(-0.18 to 0.47)
Total R^2	**62**			

Self-compassion

Step 1	.09		
Gender		.04	(-0.08 to 0.15)
Age		-.06	(-0.07 to 0.03)
Job experience		-.25***	(-0.16 to 0.05)
Step 2	.32***		
Emotional demands		.43***	(0.27 to 0.43)
Self-compassion		-.34***	(-0.28 to -0.16)
Step 3			
Emotional demands x self-compassion	.03**	-.58**	(-0.53 to -0.25)
Total R^2	**44**		

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p < .05; **p < .01; ***p < .001.